State of Montana
DEPARTMENT OF CORRECTIONS
ADA ACCOMMODATION FORM

Inmate Name: _____ DOC ID #: _____

Age:_____ Housing location:_____ Date Requested ____/____/____

Inmate's current assignment status and work location:_____

☐ Initial ☐ Renewal ☐ Items Issued

ADA COORDINATOR MUST COMPLETE

Accommodation Requested: _____ Duration:_____
Directions:_____

_____

Prescriber:_____

Reason Accommodation is necessary, check all that applies:

☐ Inmate strictly meets criteria for ADA accommodation

☐ Health Services records support need for accommodation

☐ Alternative accommodations have been explored and found ineffective

☐ Other – Explain:_____

_____

_____

Coordinator's Signature:_____ Date: ____/____/____

Comments:

☐ Approved as Requested ☐ Approved with Modification ☐ Denied until Further Review

Explanation:_____

_____

_____

Name:_____

Signature:_____ Date: ____/____/____

Instructions:

1. Requests will be reviewed and returned within two weeks.
2. If an accommodation is needed immediately, this form will be filled out and the item provided. A copy will be forwarded to the ADA coordinator for review.